

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL****FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:

0 1 - 0 0 4

2. STATE:

Minnesota

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

January 1, 2001

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

Sec. 1902(aa) & Sec. 423 of BIPA '00 (incorporated
by reference in P.L. 106-554)

7. FEDERAL BUDGET IMPACT:

a. FFY '01 \$ 550,592

b. FFY '02 \$ 806,078

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.19-B, pp. 4, 5, 66-66a

Preprint p. 58

4a, 4b, 4c

5a, 5b, 5c

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Att. 4.19-B, pp. 4, 5, 66-66a

10. SUBJECT OF AMENDMENT:

Rates: RHCs, FQHCs, transportation

11. GOVERNOR'S REVIEW (Check One):

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Mary B. Kennedy

14. TITLE:

Medicaid Director

15. DATE SUBMITTED:

March 29, 2001

16. RETURN TO:

Stephanie Schwartz
Minnesota Department of Human Services
444 Lafayette Road North
St. Paul, MN 55155-3853**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

03/30/01

18. DATE APPROVED:

8/27/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

January 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

Cheryl A. Harris

21. TYPED NAME:

Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

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MAR 30 2001

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MINNESOTA
MEDICAL ASSISTANCE
Federal Fiscal Impact of TN 01-04
Attachment 4.19-B: Rate Changes for RHCs/FQHCs and Transportation

1. The Balanced Budget Act of 1997 (BBA '97) (P.L. 105-33) amended Section 1902(a)(13)(C)(i) of the Social Security Act (the Act) governing payments to rural health clinics (RHCs) and federally qualified health centers (FQHCs). That section was amended to require that beginning in Federal Fiscal Year 2000, cost-based payments to RHCs and FQHCs decreased from 100% of reasonable costs to 95% of reasonable costs. Beginning in Federal Fiscal Year 2001, the percentages were to decrease annually until Federal Fiscal Year 2004, when no required percentage was to apply.

Section 603(a)(1) of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (P.L. 106-113) further amended section 1902(a)(13)(C)(i). Although the entities still received 95% of reasonable costs for Federal Fiscal Year 2000, the percentage payment was not to decrease until Federal Fiscal Year 2003. Beginning in Federal Fiscal Year 2003, the percentages were to decrease annually until Federal Fiscal Year 2005, when no required percentage was to apply, and section 1902(a)(13)(C) was to be repealed.

Effective January 1, 2000, approved State plan amendment TN 00-03 amended Attachment 4.19-B, items 2.b. (rural health clinic rates) and 2.c. (federally qualified health center rates) to follow the percentages specified in section 1902(a)(13)(C)(i) of the Act.

Effective January 1, 2001, section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA '00), incorporated by reference in the Consolidated Appropriations Act, 2001 (P.L. 106-554), deletes section 1902(a)(13)(C) of the Act and creates a new prospective payment system for RHCs and FQHCs. New section 1902(aa) of the Act provides that existing RHCs and FQHCs, for services furnished on and after January 1, 2001, during "fiscal year 2001," are paid per visit payments equal to 100% of the average costs incurred during fiscal years 1999 and 2000 that "are reasonable and related to the cost of furnishing such services" or based on other reasonableness tests as HCFA prescribes in regulations, adjusted to take into account any increase or decrease in the scope of services furnished. Beginning fiscal year 2002, per visit payments for these entities will be equal to the amount for the preceding fiscal year increased by the percentage increase in the Medicare Economic Index for primary care services for that fiscal year, adjusted for any increase or decrease in the scope of services furnished during the fiscal year.

Because section 1902(aa) does not use the phrase "*federal* fiscal year," Minnesota will use a RHC's or FQHC's fiscal year (reporting year) end, trended to January 1, 2001.

For entities that first qualify as RHCs or FQHCs beginning on or after fiscal year 2001, the per visit payments begin in the first fiscal year that the RHC or FQHC attains qualification and will be based on 100% of the costs incurred during that year based on the rates established for similar entities with similar caseloads in the same or adjacent geographic area. If there are no similar entities, the methodology will be based on that used for developing rates for established entities or on such other tests of reasonableness established by HCFA. For each fiscal year following the fiscal year in which entities first qualify as RHCs or FQHCs, per visit payments will be based on the rates described above, for established RHCs and FQHCs.

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Section 702 of BIPA also allows States to pay RHCs and FQHCs pursuant to an "alternative payment methodology." Section 1902(aa)(6) permits an alternative payment methodology if it: (1) is agreed to by the clinic or center and the Medicaid agency; and (2) results in a payment "which is at least equal to the amount otherwise required to be paid to the center or clinic" under the prospective payment system (in other words, the prospective payment system is the payment "floor"). If a Medicaid agency wishes to provide for an alternative payment methodology, such methodology must be described in the State plan.

The Department is seeking legislative authority to permit an alternative methodology for those RHCs and FQHCs that choose to receive payments in this fashion. For those clinics and centers that choose this option, the methodology will be 100% of cost as determined using Medicare cost principles.

The following fiscal impact figures are based on the assumption that not all RHCs and FQHCs will request payment using the alternative payment methodology. However, because a cost-based payment using historical methodology (and 2001 costs) instead of a prospective payment system (using average costs incurred in fiscal years 1999 and 2000) is expected to result in higher payments, the Department estimates that 80% of clinics and centers will choose the alternative payment methodology.

Preprint page 58 is amended to cite to current RHC and FQHC statutes and regulation, and add a citation to BIPA '00. Preprint page 58 also deletes the requirement that the Department meets the requirements of section 6303 of the State Medicaid Manual (in reference to FQHC payments). Section 6303 is not current, and an identical reference was deleted in approved State plan amendment TN 00-03.

	<u>FFY 2001*</u>	<u>FFY 2002</u>
	(in 1000's)	
Federal costs/(savings)	\$279,058	\$444,033
State costs/(savings)	<u>\$267,043</u>	<u>\$444,033</u>
Total MA Cost	\$546,101	\$888,066

2. Current State plan rate methodology for ambulance transportation (Attachment 4.19-B, item 24.a.) provides that such transportation is paid the lower of (1) submitted charge; or (2) the 50th percentile of the Medicare prevailing charge for 1982, plus a 10.75 percent increase over the base rate. Effective July 1, 1999, this rate was increased 5 percent.

Section 423 of BIPA '00 provides for a full inflation update in ambulance payments for calendar year 2001. Therefore, the reference in Attachment 4.19-B, item 24.a. to the 1982 charge is deleted.

	<u>FFY 2001*</u>	<u>FFY 2002</u>
	(in 1000's)	
Federal costs/(savings)	\$271,534	\$362,045
State costs/(savings)	<u>\$259,740</u>	<u>\$346,320</u>
Total MA Cost	\$ 531,274	\$708,365

January 1, 2001-September 30, 2001

Revision: HCFA-PM-93-6 (MB)
August 1993

OMB No.: 0938-

State/Territory: MINNESOTA

Citation 4.19(b)

42 CFR 447.201

42 CFR 447.302

52 CFR 28648

1902(a)(15), 1902(aa),

1903(a)(1) and 1920

of the Act, Sec. 702 of

the Medicare, Medicaid,

and SCHIP Benefits

Improvement and Protection

Act of 2000 (incorporated by

reference in P.L. 106-554)

In addition to the services specified in paragraphs 4.19(a), (d), (k), ~~(l), and (m)~~, the Medicaid agency meets the following requirements:

- (1) Section ~~1902(a)(13)(E)~~ 1902(aa) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905(a)(2)(C) of the Act. ~~The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services.~~ ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys).
- (2) ~~Sections 1902(a)(13)(E) and 1926~~ Section 1902(aa) of the Act, and 42 CFR Part 447.371, ~~Subpart D~~, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan.

ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.

1902(a)(10) and
1902(a)(30) of the
Act

SUPPLEMENT 1 TO ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.

TN No. 01-04
Supersedes
TN No. 93-27

Approval Date _____ Effective Date 01/01/01

STATE: MINNESOTA
Effective: January 1, 2001
TN: 01-04
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ATTACHMENT 4.19-B
Page 4

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic.

A. ~~Provider Clinics~~

~~For clinics of rural hospitals with fewer than 50 beds, payment shall be pursuant to 42 CFR §447.371(a) using the methodology established for independent clinics in 42 CFR §447.317(b) or (c)(1) or (3), at the percentages specified in §1902(a)(13)(C)(i) of the Social Security Act.~~

~~For clinics of urban hospitals, or clinics of rural hospitals with 50 or more beds, payment shall be pursuant to 42 CFR §447.371(a) using the methodology established for independent clinics in 42 CFR §447.371(b) or (c)(1) and (3), at the percentages specified in §1902(a)(13)(C)(i) of the Act, applying the limit of §1833(f) of the Act to Medicare service costs.~~

B. ~~Independent Clinics~~

~~For clinics that do not offer ambulatory services other than rural health clinic services, payment shall be pursuant to the methodology in 42 CFR §447.371(b), at the percentages specified in §1902(a)(13)(C)(i) in accordance with the PPS methodology of §1902(aa) of the Social Security Act, applying the limit of §1833(f) of the Act to Medicare service costs.~~

~~For clinics that offer ambulatory services other than rural health clinic services, payment shall be pursuant to the methodology in 42 CFR §447.371(c)(1) and (3), at the percentages specified in §1902(a)(13)(C)(i) in accordance with the PPS methodology of §1902(aa) of the Act, applying the limit of §1833(f) of the Act to Medicare services costs.~~

A clinic receives payment based on payment methodology in effect on December 31, 2000 until its prospective payment system (PPS) rate(s) is/are determined in accordance with §1902(aa) of the Social Security Act. The Department will reconcile a clinic's payments back to January 1, 2001 when the clinic's PPS rate(s) is/are determined. PPS rates for clinics will include a rate for dental services, if provided, and a rate for all other rural health clinic

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- 2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic.

services of the provider or provider group.

Prospective Payment System (PPS) Methodology

Rates are computed using a clinic's fiscal year trended forward to December 31, 2000. For the purposes of compliance with §1902(aa)(3) of the Act, the inflation of the rate will occur each year on January 1. January 1 through December 31 will be the "fiscal year." If applicable, the clinic must provide information regarding changes in the scope of services, including the budgeted cost of providing new services and any projected increase or decrease in the number of encounters due to the change. Any adjustment to the clinic's rate for changes in the scope of services will be effective on the first day of the month following the scope of services change. When determination of the revised PPS rate occurs after the revised rate's effective date, retroactive claims adjustments to the revised rate will be made back to the effective date.

In order to comply with §1902(aa) of the Act, the Department utilizes a formula using a clinic's fiscal year 1999 and fiscal year 2000 cost report information trended forward to December 31, 2000. The trended costs for the two fiscal years are combined and divided by the combined encounter information for the two years, resulting in the average cost rate. Encounters include all face-to-face encounters provided by clinic professionals, including all encounters provided by clinic staff outside of the clinic to clinic patients.

In order to comply with §1902(aa)(4) of the Act, for a clinic that first qualifies as a clinic provider beginning on or after fiscal year 2000, the Department will compare the new clinic to other clinics in the same or adjacent areas with similar case loads. If no comparable provider exists, the Department will compute a clinic-specific rate based upon the clinic's budget or historical costs adjusted for changes in the scope of services.

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- 2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic.

A clinic providing services under a contract with a Medicaid managed care entity (MCE) will receive quarterly state supplemental payments for the cost of providing such services. The supplemental payments are the difference between the payments the clinic receives from the MCE and the payments the clinic would have received in accordance with the PPS methodology of §1902(aa) of the Act.

Alternative Payment Methodology

For a rural health clinic paid under an alternative payment methodology in accordance with §1902(aa)(6) of the Act, the methodology is 100% of cost as determined using Medicare cost principles.

The Department will pay for clinic services as follows:

- A. A clinic will be paid for the reasonable cost of clinic services and other ambulatory services, less the cost of providing dental services, on the basis of the cost reimbursement principles in 42 CFR Part 413. The Department will pay for other ambulatory services and clinic services, less the cost of providing dental services, at a single rate per visit based on the cost of all services furnished by the clinic.
- B. A clinic will be paid for providing dental services at a rate per visit based on the cost of dental services furnished by the clinic.

A rural health clinic providing services under a contract with a Medicaid MCE will receive quarterly state supplemental payments for the cost of providing such services. The supplemental payments are an estimate of the difference between the payments the clinic receives from the MCE and the payments the clinic would have received in accordance with the alternative payment methodology of §1902(aa)(6) of the Act. At the end of the clinic's fiscal year, the total amount of supplemental and MCE entity payments received will be reviewed against the amount that the actual number of visits provided under the clinic's contract with the MCE would have yielded under the alternative payment methodology. The clinic will be paid

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic.

the difference between the amount calculated using the alternative payment methodology and actual number of visits, and the total amount of supplemental and MCE payments received, if the alternative amount exceeds the total amount of supplemental and MCE payments. The clinic will refund the difference between the alternative amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received, if the alternative amount is less than the total amount of supplemental and MCE payments.

For rural health clinic payments, "visit" means a face-to-face encounter between a clinic patient and any health professional whose services are paid under the State plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

The State uses the clinic's audited Independent Rural Health Clinic/Freestanding Federally Qualified Health Center worksheet, Statistical Data, and Certification Statement to establish payment rates. The State makes adjustments for:

- (1) Medicaid coverage of services that differs from Medicare coverage;
- (2) the applicable visits; and
- (3) the establishment of a separate dental payment rate, if dental services are provided.

The State limits like services for Medicare and Medicaid to the respective Medicare limit for the year. Time periods that span more than one calendar year are limited to the respective Medicare limit for each time period.

For purposes of this item, "provider clinic" means a clinic as defined in 42 CFR §447.371(a); "rural health clinic services" means those services listed in 42 CFR §440.20(b); "ambulatory services" means those services listed in 42 CFR §440.20(c).

STATE: MINNESOTA
Effective: January 1, 2001
TN: 01-04
Approved:
Supersedes: 00-03

ATTACHMENT 4.19-B
Page 5

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- 2.c. Federally qualified health center (FOHC) services and other ambulatory services that are covered under the plan and furnished by a FOHC.

~~Payment shall be made in accordance with §1902(a)(13)(C)(i) of the Social Security Act.~~

A FOHC receives payment based on payment methodology in effect on December 31, 2000 until its prospective payment system (PPS) rate(s) is/are determined in accordance with §1902(aa) of the Social Security Act. The Department will reconcile a FOHC's payments back to January 1, 2001 when the FOHC's PPS rate(s) is/are determined. PPS rates for FOHCs will include a rate for dental services, if provided, and a rate for all other FOHC services of the provider or provider group.

Prospective Payment System (PPS) Methodology

Rates are computed using a FOHC's fiscal year trended forward to December 31, 2000. For the purposes of compliance with §1902(aa)(3) of the Act, the inflation of the rate will occur each year on January 1. January 1 through December 31 will be the "fiscal year." If applicable, the FOHC must provide information regarding changes in the scope of services, including the budgeted cost of providing new services and any projected increase or decrease in the number of encounters due to the change. Any adjustment to the FOHC's rate for changes in the scope of services will be effective on the first day of the month following the scope of services change. When determination of the revised PPS rate occurs after the revised rate's effective date, retroactive claims adjustments to the revised rate will be made back to the effective date.

In order to comply with §1902(aa) of the Act, the Department utilizes a formula using a FOHC's fiscal year 1999 and fiscal year 2000 cost report information trended forward to December 31, 2000. The trended costs for the two fiscal years are combined and divided by the combined encounter information for the two years, resulting in the average cost rate. Encounters include all face-to-face encounters provided by FOHC professionals, including all encounters provided by FOHC staff outside of the FOHC to FOHC patients.

STATE: MINNESOTA
Effective: January 1, 2001
TN: 01-04
Approved:
Supersedes: 00-03

ATTACHMENT 4.19-B
Page 5a

2.c. Federally qualified health center (FOHC) services and other ambulatory services that are covered under the plan and furnished by a FOHC.

In order to comply with §1902(aa)(4) of the Act, for a FOHC that first qualifies as a FOHC providers beginning on or after fiscal year 2000, the Department will compare the new FOHC to other FOHCs in the same or adjacent areas with similar case loads. If no comparable provider exists, the Department will compute a FOHC-specific rate based upon the FOHC's budget or historical costs adjusted for changes in the scope of services.

A FOHC providing services under a contract with a Medicaid managed care entity (MCE) will receive quarterly state supplemental payments for the cost of providing such services. The supplemental payments are the difference between the payments the FOHC receives from the MCE and the payments the FOHC would have received in accordance with the PPS methodology of §1902(aa) of the Act.

Alternative Payment Methodology

For a FOHC paid under an alternative payment methodology in accordance with §1902(aa)(6) of the Act, an interim rate is established, subject to reconciliation at the end of the cost reporting period, using cost finding principles of 42 CFR §413. The alternative payment methodology is 100% of cost as determined using Medicare cost principles.

The Department will pay for FOHC services as follows:

- A. A FOHC will be paid for the reasonable cost of FOHC services and other ambulatory services, less the cost of providing dental services, on the basis of the cost reimbursement principles in 42 CFR Part 413. The Department will pay for other ambulatory services and FOHC services, less the cost of providing dental services, at a single rate per visit based on the cost of all services furnished by the FOHC.
- B. A FOHC will be paid for providing dental services at a rate per visit based on the cost of dental services furnished by the FOHC.

2.c. Federally qualified health center (FOHC) services and other ambulatory services that are covered under the plan and furnished by a FOHC.

A FOHC providing services under a contract with a Medicaid MCE will receive quarterly state supplemental payments for the cost of providing such services. The supplemental payments are an estimate of the difference between the payments the FOHC receives from the MCE and the payments the FOHC would have received in accordance with the alternative payment methodology of §1902(aa)(6) of the Act. At the end of the FOHC's fiscal year, the total amount of supplemental and MCE entity payments received will be reviewed against the amount that the actual number of visits provided under the FOHC's contract with the MCE would have yielded under the alternative payment methodology. The FOHC will be paid the difference between the amount calculated using the alternative payment methodology and actual number of visits, and the total amount of supplemental and MCE payments received, if the alternative amount exceeds the total amount of supplemental and MCE payments. The FOHC will refund the difference between the alternative amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received, if the alternative amount is less than the total amount of supplemental and MCE payments.

For FOHC payments, "visit" means a face-to-face encounter between a FOHC patient and any health professional whose services are paid under the State plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

The State uses the FOHC's audited Independent Rural Health Clinic/Freestanding Federally Qualified Health Center worksheet, Statistical Data, and Certification Statement to establish payment rates. The State makes adjustments for:

- (1) Medicaid coverage of services that differs from Medicare coverage;
- (2) the applicable visits; and

STATE: MINNESOTA
Effective: January 1, 2001
TN: 01-04
Approved:
Supersedes: 00-03

ATTACHMENT 4.19-B
Page 5c

2.c. Federally qualified health center (FOHC) services and other ambulatory services that are covered under the plan and furnished by a FOHC.

- (3) the establishment of a separate dental payment rate, if dental services are provided.

The State limits like services for Medicare and Medicaid to the respective Medicare limit for the year. Time periods that span more than one calendar year are limited to the respective Medicare limit for each time period.

STATE: MINNESOTA
Effective: January 1, 2001
TN: 01-04
Approved:
Supersedes: 00-17

ATTACHMENT 4.19-B
Page 66

24.a. Transportation.

Through December 31, 2000, payment for life support transportation is the lower of:

- (1) submitted charge; or
- (2) 50th percentile of Medicare prevailing charge for 1982, plus a 10.725% increase over the base rate.

Effective July 1, 1999 this rate is increased 5%.

Effective January 1, 2001, payment is the lower of:

- (1) submitted charge; or
- (2) the Medicare unadjusted base rate.

If the provider transports two or more persons simultaneously in one vehicle, the payment is prorated according to the schedule for special transportation services, below. Payment for ancillary services provided to a recipient during life support transportation must be based on the type of ancillary service and is not subject to proration.

Payment for **special transportation** must be the lowest of:

- (1) submitted charge; or
- (2) medical assistance maximum allowable charge, which is a base rate of \$15.00 and, until July 1, 2001, \$1.30 per mile.

If the provider transports two or more persons simultaneously in one vehicle from the same point of origin, the payment must be prorated according to the following schedule:

<u>NUMBER OF RIDERS</u>	<u>PERCENT OF ALLOWED BASE RATE PER PERSON IN VEHICLE</u>	<u>PERCENT OF ALLOWED MILEAGE RATE</u>
1	100	100
2	80	50
3	70	34
4	60	25
5-9	50	20
10 or more	40	10

STATE: MINNESOTA

ATTACHMENT 4.19-B

Effective: January 1, 2001

Page 66a

TN: 01-04

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Supersedes: 00-17

24.a. Transportation. (continued)

Payment for **air ambulance transportation** is consistent with the level of medically necessary services provided during the recipient's transportation and .

Through December 31, 2000, payment is the lower of:

- (1) submitted charge; or
- (2) the 50th percentile of Medicare's prevailing charge for 1982, plus a 10.725% increase over the base rate.

Effective July 1, 1999 this rate is increased 5%.

Effective January 1, 2001, payment is the lower of:

- (1) submitted charge; or
- (2) the Medicare unadjusted base rate.

Payment for air ambulance transportation of a recipient not having a life threatening condition is at the level of medically necessary services which would have been otherwise provided to the recipient at rates specified for other transportation services, above.

Payment for **special transportation for a child receiving rehabilitative or personal care services identified on an IFSP or IEP** and provided by a school district during the day is determined by multiplying the number of miles the child is transported to or from a provider of rehabilitative services by the per mile rate of \$2.21.